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APPLICATION FOR REIMBURSEMENT FROM THE COMPENSATION SUPPLEMENT FUND

Michigan Department of Labor & Economic Growth
Workers' Compensation Agency
PO Box 30016, Lansing, MI 48909

☐ Initial (For Quarter)
☐ Corrected

Employer Name (Type or print) _____ Carrier File No. _____

Employee Name (Last, First, MI)					
Employee Street Address		City		State	Zip Code
Social Security Number	Date of Injury (MM-DD-YYYY)	Average Weekly Wage on Date of Injury		Date of Birth (MM-DD-YYYY)	
Name of Insurance Company or Self-Insured				Carrier I.D. Number	
Carrier Address (Street)		City		State	Zip Code
Federal Employer I.D. Number	Reimbursement Requested For: Quarter _____ Calendar Year _____			Weekly Comp. Rate on Jan. 1, 1982	

Compensation Paid Date from (MM-DD-YYYY)	Compensation Paid Date to (MM-DD-YYYY)	Weeks	Days	Supplement Percentage	Weekly Second Injury Fund Differential Benefits Paid	Weekly Compensation Supplement	Total Supplement Paid
						Total Reimbursement Requested	$ _____

☐ Date of death _____
☐ Date of redemption _____
☐ Return to work _____
☐ Other _____

Comments:

Signature of Authorized Representative (In Ink)	Name of Person to Whom Correspondence Should Be Sent (Please Print)	
Date of This Report	Address	Telephone Number

NOTICE: The initial form WC-114 must be filed within three (3) months after the end of the calendar quarter in which benefits are first paid. No subsequent reimbursements will be allowed for a period which is more than one (1) year prior to the filing date of the Form WC-114.

Authority: Workers' Disability Compensation Act, 418.352; R408.32(2)(3) Completion: Mandatory Penalty: Workers' Disability Compensation Act, 418.631; 418.801	The Department of Labor & Economic Growth will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.